This form may be completed online, printed and mailed to the address listed below.

STATE OF NEBRASKA
Department of Health and Human Services Regulation and Licensure
Credentialing Division
301 Centennial Mall South, PO Box 94986
Lincoln, NE 68509-4986

REQUEST FOR REISSUANCE OF MEDICATION AIDE REGISTRATION CARD(S)

1.	NAME:	First	Middle	Maiden	Last
2.	ADDRESS:	Street/PO/Route			
		City	State	Zip	
3.	SOCIAL SECURITY NUMBER				
4.	PROFESSION:	MEDICATION AIDE			
5.	REGISTRATION NUMBER:				

I hereby request reissuance of medication aide registration card(s):

Number of Documents Requested: _____

Reason(s) for requesting that license/certification document(s) be reissued.

Check one:

- ❒ Name Change
- ❒ Address Change
- ❒ Duplicate Copy
- ❒ Never Received
- ❒ Destroyed by Accident
- ❒ Lost
- ❒ Stolen
- ❒ Printed with the Wrong Name/Address
- ❒ Other, explain: _____

NOTE: YOU MUST SUBMIT **$10.00** FOR EACH REISSUED DOCUMENT REQUESTED.

State of _____)
) ss
County of _____)

I,_____, hereby solemnly swear that I am the Medication Aide registrant listed above

That I have requested the additional registration card(s) documents.

Dated this _____day of _____ of 20___.

Signature of Licensee:_____

SCRIBED AND SWORN TO BEFORE ME THIS ____ DAY OF _____, 20_____.

_____
NOTARY PUBLIC SIGNATURE

NOTARY PUBLIC SEAL/STAMP